REVIEW OF THE MENTAL HEALTH SYSTEM

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SUMMARY

In the Spring of 1987, the Department of Health and Social Services indicated in its Strategic Policy Overview that issues in mental health warranted an examination of the service system. Subsequently, the Department was directed by Executive Council to undertake a review of existing mental health services and future needs. This report presents the findings and views of the ad hoc Committee established for that purpose.

Because of the traditional pattern of mental health service review and development, the Committee took an approach to its task that deals more with establishing an environment and a framework from which positive change can occur, than an approach that addresses discrete, current program and service issues. Factors influencing this choice include the limited time available, the Committee composition, and perhaps most importantly, the belief that broader issues related to philosophy, policy, leadership, structure, and co-ordination must be effectively addressed within the system before rational decisions can be made about the priority to be assigned to specific funding and service development needs.

Part of the Committee's task involved the review of prior studies, reports, proposals and correspondence on the mental health service system; it was interesting to note during this process that mental health service issues had been the subject of review on several previous occasions, studies having been conducted in 1931, 1961, 1969, 1976, 1978, 1981, and 1985. There has

been surprising similarity among many of the recommendations of many of these reports.

Previous studies have identified a continuing need for on-going service and system planning and co-ordination, yet, no formal process has ever been put in place to meet this need. The Review Committee recommends that a mechanism for system planning and co-ordination be established and involve senior representatives of the many, various sub-systems delivering mental health services. (While this recommendation was being formulated among the members of the Review Committee, a similar conclusion was reached among 50 individuals from various parts of the general health care system who, in February 1988, while participating in a Health Care Forum and identifying and priorizing issues in the health care system, ranked planning and co-ordination as the first and second priorities.)

The need for a "federated" approach to planning and co-ordination of mental health services arises from the structure of the system in which there are many partners, but no single authority.

A second recurring theme among previous studies is the belief in the significance of a strong network of community support services in preventing inappropriate hospitalization. The Review Committee reiterates that belief, and recommends adoption of the goal of achieving a better balance among health promotion, prevention, and treatment.

A number of additional recommendations focus on philosophical, structural, and process re-orientation within the system (for example, adoption of a proposed set of principles as the basis for further system development, re-organization and revitalization of the Division of Mental Health, abolition of the Hillsborough Hospital Board, provision of the professional and analytical support necessary to enable the Director of Mental Health to carry out the management and leadership responsibilities of the position, improved intra- and inter-departmental communication on support service initiatives such as housing and employment, and revision of the Mental Health Act.)

Other recommendations indicate an immediate need to address a relatively small number of outstanding "pressure points" with specific action planned within the current or upcoming budget cycle in order to deal with untenable situations. These include: recruitment of a staff psychiatrist for Hillsborough Hospital to enable the implementation of bed re-use plans such as the conversion of lounge space to an acute care observation unit, upgrading levels of (nursing) staffing at Hillsborough Hospital, examination of the allocation and use of acute care psychiatric beds and development of a bed management plan for the three hospitals providing psychiatric care, examination of the future service needs of individuals currently in foster placements, and development of additional community service options.

The Committee believes that now, more than ever before, there is common concern and common philosophical ground among mental health service providers. With Government helping to create an environment for constructive and realistic problem solving, the mental health needs of Prince Edward Islanders can be more effectively addressed.

1. INTRODUCTION

1.1 Historical Perspective

Mental Health services in Prince Edward Island have a long history. The first mental health facility in the Province was opened in 1845, and remained the only "service" (a "dismal ...combination of poorhouse and jail, an...impersonal and demoralizing institution of incarceration...")[1] for the mentally ill for approximately one hundred years.

During the 1950's and 60's a service system developed which included a number of community mental health programs, such as school guidance resources, a Foster Care/Boarding Out program for individuals discharged from the Riverside Hospital, programs for the mentally retarded, and mental health programs in Summerside and Charlottetown, the latter offering extension services to Kings County residents.

In the early 1970's, influenced by the Development of the Regional Service Centre concept, school consolidation, and the expansion of federally cost-shared social services, a number of mental health programs and resources were transferred from the Department of Health to the Departments of Education and Social Services. Mental Health services became, once more, focused on the operation of Riverside (Hillsborough) Hospital.

Mental Health service needs have been the subject of at least six major reviews over the past 60 years, each one recommending the addition of some new component(s) to the system. The most recent study is that of the Mental Health Advisory Committee of 1978.

The report of the Advisory Committee, drawing on some of the recommendations of previous reports and adding some new proposals, outlined a strategy for system development which served as the basis for general direction during the three to five year period following its release.

The recommendations of the Mental Health Advisory Committee emphasized the establishment of a decentralized, community based, interdisciplinary system of mental health service, the adoption of deinstitutionalization as a guiding principle, the development of a range of residential, vocational, social, and recreational options in the community, the establishment of psychiatric units in the province's two main acute care hospitals, the need for modernization of Hillsborough-Riverside with a reduced number of beds and an increased rehabilitation capacity, the establishment of a separate program and facility for disturbed adolescents, the transfer of administrative responsibility for Hillsborough Hospital from government to the Board of the Queen Elizabeth Hospital, the eventual phasing out of the Division of Mental Health, and the conversion of the role of the Director of Mental Health from direct management to consultancy.

The 1978 Advisory Committee also recommended that Government "view the existing lack of co-ordination of services now being delivered by various departments, private and voluntary bodies as a matter of urgent concern"[2] and that a Human Services Committee of Executive Council be established consisting of Deputy Ministers of Health, Education, Social Services, and Justice, to address the task of integrating, co-ordinating, and modifying service programs on a continuing and active basis.

A number of these recommendations were implemented. Three interdisciplinary mental health teams have been established regionally under the Division of Community Mental Health, Hillsborough-Riverside has undergone major modernizing reconstruction and the number of beds has been reduced from 233 to 191, and psychiatric units have been established at the Queen Elizabeth Hospital (30 beds) and at the Prince County Hospital (16 beds).

Unfortunately, on-going development, rationalization, and stabilization of the system had lost momentum and direction by 1983, largely due to a high level of turnover among psychiatrists, managers, and planners who had been instrumental in charting the course, occurring at a time of government fiscal restraint. In the face of restricted resources and shifting priorities, government's desire and ability to further adjust the mental health system was diminished.

By the mid 1980's the effects of unresolved issues were beginning to show. For example:

- In 1985, a committee was established to conduct a "Role Study" of Hillsborough Hospital. The committee indicated that implementation of the recommendations of the 1978 Advisory Committee had impacted adversely on Hillsborough Hospital in that:
  - the ratio of professional staff to patients was reduced when hospital staff were transferred to other parts of the expanded mental health system.
  - Hillsborough Hospital adjusted its ratio of acute care beds to accommodate acute admissions when the demand for acute psychiatric treatment exceeded the resource limits of the Queen Elizabeth Hospital, but no accompanying increase in professional staff occurred.
  - although programs were initiated at Hillsborough Hospital to bridge patients' adjustment between institutional and community living, access to community residential programs, which tended to focus on serving the mentally retarded, was difficult for Hillsborough Hospital patients.
- In 1986, a critical shortage of acute care beds at the Queen Elizabeth Hospital was identified in correspondence and in meetings between the P.E.I. Psychiatric Association and the Minister and Deputy Minister of

Health and Social Services. As recently as November 1987, the continuing urgency of pressure on the acute care system was reiterated to the Minister by the Head of the QEH Department of Psychiatry in a letter describing frequent relocation of patients, interruption of treatment, and premature discharge, all aimed at accommodating new emergency admissions, but in fact contributing to a longer than necessary hospitalization or a higher than necessary rate of relapse among those affected.

In the past five years, resource adjustments in mental health services have occurred largely in response to various financial crises and without the benefit of any overall direction.

1.2 The Mental Health System Review 1987-88

In its 1987 Strategic Policy Overview, the Department of Health and Social Services indicated that "the Mental Health System in Prince Edward Island seems to have suffered from a degree of structurally induced confusion."[3] The Policy Overview pointed out that there are a number of Divisions within the Department overlapping in the delivery of mental health services, but that no services are actually delivered by the Division of Mental Health.

The need for improved planning and co-ordination was identified, as was the eagerness of the various parties involved to participate in a constructive planning process. It was proposed that the system

be re-examined, that the delivery of services be rationalized, and that a strategy for the future be developed.

Following review of the Health and Social Services Strategic Policy Overview, Executive Council directed the Department to undertake "an in-depth review of existing mental health services and future needs....with report and recommendations to Policy Board and then Council by 31 March 1988." Council directed that the review encompass "a review of the Mental Health Act, the relationship between acute units, community services, and Hillsborough Hospital, identification of service needs, manpower planning, and such other aspects as the department may fee' should be included."[4]

1.3 Committee Composition

In the fall of 1987, the composition of a small Mental Health System Review Committee was finalized. The Committee was chaired by the Assistant Deputy Minister of Health and Social Services, and included the Department's Directors of Mental Health, Community Mental Health, and Aging and Extended Care, along with the Executive Director of the P.E.I. Division of the Canadian Mental Health Association, and the Director of Planning from the Hospital and Health Services Commission.

1.4 Terms of Reference

From the outset it appeared that the scope of the immediate task could, for a number of reasons, be neither as broad nor as "in-depth" as had been outlined in the Executive Council decision.

First of all, it was acknowledged that one of the most frequently cited issues of urgency, namely, the shortage of psychiatrists in the Province, was being addressed by the Medical Manpower Committee of the Hospital and Health Services Commission. Since some of the members of the Review Committee were to be consulted on this issue, it was agreed that the review would not address the question of psychiatric manpower, other than to recognize the shortage of psychiatrists, and the need for innovative recruitment approaches to attract new psychiatrists to Prince Edward Island to enable the mental health system to function more effectively.

Secondly, it was considered neither feasible nor advisable to undertake a review of the Mental Health Act as part of the immediate review process. The Review Committee regards revision of the Mental Health Act as a significant assignment, which should be guided by the outcome of the review itself, and therefore one which should occur after the review and not as a part of it.

And finally, it was agreed that, in order to appropriately identify and address issues, opportunities, and initiatives in a dynamic,

interactive system in a comprehensive way, an on-going planning, monitoring, and review process was far preferable to a single, time-limited exercise which might be useful in the short term, but perhaps useful thereafter only as a starting point for some subsequent review.

In the course of its work, the Committee reviewed a number of studies, reports, and summaries of meetings and discussions, all of which attempted to resolve issues in the mental health system. If these efforts share a common shortcoming it is that they were undertaken as discrete exercises outside the context of a larger planning process. Refining and strengthening the mental health system requires an on-going commitment from many quarters to work together.

Within these parameters then, the review committee (1) examined the existing system and analyzed outstanding issues to identify those deficiencies considered to be the most critical and in need of immediate attention, and (2) recommended steps to be taken to resolve them.

1.5 Process

The Committee began its work in mid-December 1987, and continued to meet approximately every two weeks thereafter until the middle of March. The Committee assessed the evolution of service philosophy,

analyzed data on the psychiatric patient population in both acute and chronic care hospitals and on patterns of hospitalization, reviewed the current structural context for the delivery of mental health services by government, and examined outstanding service issues and needs as presented in various letters, proposals, studies, and reports, including departmental statements of program direction for Mental Health, Community Mental Health, Aging and Extended Care, Child Welfare, Addiction Services, and the Adolescent Unit.

2. PHILOSOPHY AND PRINCIPLES

2.1 Philosophical Evolution

Traditionally, the term "mental health" has been linked to services for the mentally ill and has been defined accordingly as the absence of mental disorder.

Ten years ago, the Mental Health Advisory Committee considered that "the purpose of a mental health service is to relieve, when possible, the morbid sufferings of men, women, and children, whether due to diseases of the mind or circumstances"[5] and stated that, "Whilst a mental health service will be preventive when it can, it addresses itself to, not the needs of the healthy and well functioning, but those of the distressed and disabled.."[6]

Current thinking on health, health care, and health promotion, provides a new context in which the mental health service system must be viewed. In 1986 the Minister of Health and Welfare Canada released a Federal Government discussion paper, Achieving Health for All: A Framework for Health Promotion in which health is portrayed as a resource - an essential dimension of everyday living which allows people the opportunity to make choices and gain satisfaction from their ability to manage and even change their circumstances and their surroundings to better cope with the demands of their environment. This broader philosophical orientation to (mental) health as a resource emphasizes its positive characteristics and highlights its relation to social and environmental, as well as individual, factors.

Such an orientation challenges the way the formal mental health care system defines needs and delivers services. It has been estimated that up to 30% of the patients of Hillsborough Hospital are there because they lack "life management skills" and because they are, for varying reasons unable to meet their need for security and freedom from the stress and distress of daily living outside the hospital. Does this mean they actually need to be hospitalized, or does it mean that only the hospital can, as the system is now structured, provide them adequate support and security? A system aimed at "relieving...morbid sufferings ...whether due to disease of the mind or circumstances" will apply

its resources differently than a system which places a high value on strengthening life management capability.

This is not to imply that the mental health system in P.E.I. gives no attention to the promotion of mental health, nor that health promotion, illness prevention, and treatment are discrete programs or activities. In fact, many of the existing mental health services are very much oriented to strengthening functional capability. Still, an even better balance of recognition and emphasis among mental fitness, prevention of dependency, and treatment of mental illness can be achieved.

The Minister of Health and Welfare Canada contends that "The primary challenge in the health field is to move beyond cure and care, without for a moment abandoning our duty to the sick and infirm."[7] As chronic conditions and mental health problems have replaced communicable diseases as the predominant health issues for Canadians in the latter half of this century, this challenge is particularly relevant to the mental health service system.

2.2 Principles for the Mental Health Service System

The effective translation of philosophy into policies and programs requires that common beliefs and values be shared among the participants in the system. These beliefs and values must serve as basic principles guiding all decisions affecting the system.

The following general principles are proposed by the Review Committee as an appropriate basis for further system development.

- mental health system planning should be an on-going, collaborative intersectoral process, in recognition of the complexity and interactivity of factors contributing to many mental health problems (e.g. unemployment, inadequate housing, discrimination, domestic stress, etc.) and in recognition of the benefits of exposure to new thinking and new approaches.
- the mental health system should be consumer oriented, open to inviting the participation of its consumers in program and service planning and delivery.
- the mental health system should strengthen environments that foster rather than hinder recovery and responsibility by encouraging individuals to contribute to their own health through the development and application of coping skills which enable them to exercise control over their conditions and their lives.
- the mental health system should recognize the natural capacity of individuals and communities for positive health and growth.
- the mental health system should have the flexibility to respond to needs by providing services and supports at "a level of least intrusion" and in a setting as close to a natural/normal living environment as possible.
- the physical setting of an institution may be an appropriate community for some individuals, while others, living on their own, may be deprived of "quality of life" factors; "community"

and "institution" should be seen not only as locations, but also as attitudes and approaches to provision of service and support.

- the structure of the system and the allocation of resources within it should recognize and respect the importance of each of its components and the need for a balance of emphasis among them.

3. OPPORTUNITIES AND ISSUES

3.1 Planning and Co-ordination

A review of past studies and reports on the mental health system revealed that some of the service deficiencies noted over the past ten years are still outstanding. Today, however, the climate for addressing them co-operatively is significantly more positive than ever before.

In 1978, the Advisory Committee reported that many of the groups making submissions "deplored the lack of co-operation between agencies, which....bordered at times on mistrust and hostility, with a consequent failure to co-ordinate activities....This failure was frequently ascribed to a lack of clearly stated objectives, absent leadership, and to ill defined services. Groups appeared to have considered that most logically, direction and leadership should be provided by the Division of Mental Health, but few betrayed signs of preparedness to negotiate upon priorities."[8]

A paper prepared in May, 1985, entitled Mental Health Service Requirements cited the need for two types of co-ordination. It was noted that case co-ordination was needed at the individual level to provide clients in the community with a fixed point of contact to assess and monitor needs and to negotiate for services from the various components of the system. A second type of co-ordination, among organizations and programs at the provincial - systems level was also called for.

The need for this latter type of co-ordination was reinforced in a document prepared in December 1986 on Issues in the Mental Health System. This paper indicated that the lack of an overall planning process to co-ordinate the implementation of the many significant changes in the system - from the amalgamation of the Departments of Health and Social Services, to the establishment of community based residential and vocational services, to the transfer of administrative responsibility for Hillsborough Hospital from the Division of Mental Health to the Division of Aging and Extended Care - had contributed to confusion, apathy, low morale, and poor service. This was not to imply that any of these changes were ill planned or poorly implemented, but rather, that they occurred in relative isolation of each other.

This document drew the conclusion that "the...situation reflects a lack of continuity in leadership in the mental health system." It has, for the past few years been difficult to recruit and retain an

appropriately qualified Director of Mental Health, and the successive vacancies and re-orientations have no doubt contributed to limited system wide planning and co-ordination."[9]

In June 1987, the position of Director of Mental Health was filled. Both the act of appointing a full-time Director and the individual selected, seem to have contributed to an encouraging extension throughout the system of a spirit of optimism, goodwill, and co-operation which had previously existed primarily at a field level.

This is seen by the members of the current review committee as one of the major assets of today's mental health system.

However, no system can run on goodwill alone. Structures and mechanisms must be in place to facilitate appropriate communication and to minimize frustration and inefficiency.

Given the number of autonomous organizations in Prince Edward Island with responsibilities in the field of mental health, a formally established and officially recognized body is needed to foster effective intersectoral participation of authorities from the major components of the service system - Acute Care, Chronic/Extended Care, and community services - in on-going system/service problem solving, planning, analysis, evaluation, adjustment, and development.

3.2 Organization and Structure

A number of distinct groups are involved in the direct delivery of mental health services in Prince Edward Island (private practice psychiatrists, two General Hospitals, at least two operational Divisions of the Department of Health and Social Services [10] and the local division of the Canadian Mental Health Association).

The Review Committee sees the potential strength of a multi-jurisdictional system, but recognizes the need for formally designated leadership if the benefits of shared responsibility are to be realized and the pitfalls avoided. In this regard, the Committee sees the Director of Mental Health as the focal point for leadership in the mental health system.

However the organizational environment in which the Director must function, frustrates rather than facilitates leadership effectiveness. As the Department of Health and Social Services is currently structured with respect to the delivery of mental health services, the role of the Director of Mental Health exists in a state of organizational limbo with neither the authority nor the control of supporting resources necessary to carry out the responsibilities assigned to the position.

Since 1984, Hillsborough Hospital has been a part of the Division of Aging and Extended Care. The Division of Community Mental Health has no formal responsibility to the Director of Mental Health, and the Division of Mental Health exists on paper only.

It could be assumed that this situation may have developed in support of the plan proposed by the 1978 Advisory Committee, which recommended that "when mental health services have been established, lasting integration with other services should be ensured by a phased disbandment of the Division of Mental Health with the transfer of professional staff to other departments of Government and to the system of private practice, leaving in the Division only a small number of professionals capable of assuring standards and formulating policy". It was intended at that time that the Director of Mental Health would eventually serve as a part-time consultant to the Hospital and Health Services Commission.

However, inconsistent with such an assumption, are the expectations outlined in the Position Description developed for the recruitment of a new Director of Mental Health/Physician-in-Chief for Hillsborough Hospital in 1986, which generally stated the functions as those of "a senior program manager with responsibility for the provision of mental health services on a regional basis through in-patient facilities and through multi-disciplinary regional mental health teams and in co-operation with other helping agencies and groups."[12]

The Review Committee believes that the Director's job description outlines a necessary and appropriate set of responsibilities, but that the organizational structure does not allow the Director to perform the duties.

As well, the Review Committee questions the need for the Hillsborough Hospital Board of Directors. The Board is established under the Hillsborough Hospital Act to serve in an advisory capacity to the Minister on matters related to charges for hospitalization, staff qualifications, and standards of patient care. The annual cost of Board administration (members' honouraria and mileage reimbursement for monthly meetings) is approximately $12,000.

In view of the responsibilities of the Director of Mental Health, the Deputy Minister of Health and Social Services, and the Minister, for policy and management at Hillsborough Hospital, and in view of the additional responsibilities of the Civil Service Commission and Treasury Board for personnel and fiscal matters at Hillsborough Hospital, the degree to which the Board of Directors is necessary or able to carry out any meaningful role is questionable.

A re-organization of mental health resources and reporting relationships within the Department should be undertaken to correct

structural anomalies. The Division of Mental Health should be re-established as a viable organizational entity, and both Hillsborough Hospital and Community Mental Health should be a part of the Division. The Hillsborough Hospital Act should be repealed and the Board of Directors abolished. The Director of Mental Health should be assured ready access to analytical and administrative support necessary to engage in the kind of policy and management evaluation, co-ordination, and consultation required to stengthen and re-orient the service system and to enable her to fulfill her assigned responsibilities.

3.3 General Hospital Services

3.3.1 Prince County Hospital

The development of acute care psychiatric in-patient units in the Province's general hospitals was recommended as long ago as 1931, but was not actually accomplished until 1980 when the 16 bed unit was opened in the Prince County Hospital

The 1981 report of the Mental Health Services Review recommended that general hospital psychiatric units be designated as psychiatric facilities under the Mental Health Act in order that hospitals operate to the maximum benefit of the community by treating both voluntary and

involuntary patients. This did not occur in the case of the Prince County Hospital until 1986.

Contributing to the delay was the difficulty in attracting psychiatrists to the Summerside area. This remains a problem. Without additional psychiatry services in Summerside and additional professional support staff in the hospital unit, the fact that the Prince County Hospital Psychiatric Unit is "designated" is largely meaningless, as the unit is not, at present, equipped to manage involuntary patients.

This is not to say that the unit does not provide a valuable service in Prince County and in the mental health system generally. Many difficult psychiatric patients are admitted and treated there. The availability of the unit in Prince County enables voluntary patients to receive care in or close to their home community, and avoids additional overload in the Queen Elizabeth and Hillsborough Hospitals.

For the past few years the Hospital and Health Services Commission has budgeted funds to upgrade staffing in the Prince County Hospital Psychiatric Unit to enable the unit to accommodate involuntary patients. The Review

Committee questions the practicality of using the funds for this purpose at this time. Until there is a second psychiatrist associated with the Unit, it is not feasible to provide the level of service required to comply with the Mental Health Act.

The service needs and priorities of the Prince County area have not yet been fully analyzed and are not yet fully understood within the broader system. This underlines again the importance of planning and co-ordination, and the importance of involving appropriate representatives of regional services in this process.

3.3.2 Queen Elizabeth Hospital

The Psychiatric Unit at the Queen Elizabeth Hospital has experienced a high demand for service for some time, with the number of patients in need of hospital admission exceeding the number of beds available.

In May 1986 the hospital Board sought legal advice regarding the practice of psychiatrists placing certain patients on temporary leave from the hospital to accommodate involuntary and other emergency admissions. The Board was advised that this action, seen as an

attempt to create capacity that did not really exist, unfairly established a legal risk for both the doctors and the hospital that neither ought to have been expected to bear.

As a result, the practice was discontinued, but the psychiatrists had to find another way to deal with the high demand. The solution, unsatisfactory as it is,has been to move patients out of the Psychiatric Unit into beds in other units of the hospital. In such cases, the patients have suffered discontinuity in treatment, improper follow-up, and frequently (owing to the precedence of emergency admissions to the other units) premature discharge and early relapse/re-admission.

At one time, the P.E.I. Psychiatric Association had stated that "preferably and ideally, our opinion is that the best resolution of the acute psychiatric bed shortage would be to have a major reconstruction project, adding a ten bed wing on to the present Unit 9 at the Queen Elizabeth Hospital, with at least five of these beds being an acute, intensive, psychiatric care unit."[13] However, in November 1987, the Head of the Psychiatry Department, in a letter to the Minister of Health and Social Services, indicated that a number of alternatives

had been discussed among psychiatrists and community agencies (e.g. further development of non-hospital residential and therapeutic services, conversion of available space in Hillsborough Hospital to accommodate an intensive care/observation unit) and that availability of such alternatives could alleviate pressure on the acute care system, avoiding, or at least delaying, costly construction and expansion in the general hospital.

The Review Committee acknowledges the seriousness of the situation at the Queen Elizabeth Hospital, and is encouraged by the hospital's willingness to pursue alternatives to expansion.

For a number of reasons, the Committee does not consider the addition of new hospital beds to the system as an appropriate solution at this time:

- The demand pressure on the Queen Elizabeth Hospital is related to factors other than simply the number of beds. These include: availability of community supports, low staff (i.e. Nurse/patient) ratios, organization and management of the unit, availability of other

professional staff (i.e. Psychologists, Occupational Therapists, Social Workers) and inappropriate or limited use of Hillsborough Hospital services due to staff and program limitations of that institution.

- The current 30 bed unit is considered to be a manageable size for a psychiatric unit in an acute care setting. A larger unit would require a different management model (for example, employment of a salaried full-time psychiatrist) to ensure the availability of appropriate treatment.

- A focus on "beds" rather than on individuals and their varying needs for different levels and types of support, although perhaps an expected reaction to high pressure circumstances, appears to reflect an orientation to more restrictive treatment services at the most costly end of the service scale.

- 1987 cost figures from the Hospital and Health Services Commission indicate a minimum requirement of $750,000 to construct a ten bed addition to the Hospital, and another minimum of $500,000 a year for on-going operation. These expenditures could be made, and yet still not alleviate the pressure.

Nonetheless, an upward adjustment of the number of acute care psychiatric beds within the existing total psychiatric bed complement may be appropriate. An examination of the allocation of acute care psychiatric beds among the two general hospitals and Hillsborough Hospital should be undertaken with a view to establishing a bed management plan which would enable more efficient use of the psychiatric beds currently available.

Adherance to such a plan, along with greater availability of a fuller range of community based mental health support service options should help alleviate pressure on the Queen Elizabeth Hospital.

3.4 Hillsborough Hospital

With its focus on deinstitutionalization, the long-range plan of the 1978 Advisory Committee, projected a relatively minor role for Hillsborough Hospital in the overall mental health system. It was intended that the widespread availability of community support services, including private practice psychiatrists, would enable reduction of the patient population to approximately 100, and that the provision of all acute psychiatric in-patient services in general hospitals would redefine Hillsborough Hospital as a facility for relatively low intensity care of a long-term rehabilitative or custodial nature.[14]

Because the vision of the 1978 Report was never fully realized, and because of the leadership issues which evolved as new system components developed independent of each other, Hillsborough Hospital has suffered a slow stagnation. While it may have been assumed that Hillsborough Hospital would be needed only for low-intensity extended care, it has not in fact been limited to this level of service. Hillsborough Hospital accommodates patients whose condition or behaviour is too extreme for treatment or management in any other setting, including community residences (family homes, foster homes, group homes, community care facilities), nursing homes/manors, addiction treatment facilities, and general hospitals.

Provision of the following services should be recognized as appropriate responsibilities of Hillsborough Hospital:

- rehabilitative treatment for individuals suffering from severe psychiatric illness and needing isolation, or hospitalization for a period of more than 3-6 weeks.
- care, control, and treatment of individuals exhibiting extreme or self-injurious behaviour disturbances, violence, destructiveness, or disorientation.
- observation and assessment in a secure setting of patients with severe personality disorders or acute psychoses.

- assessment and treatment of the psychogeriatric population whose behaviour cannot be accommodated in a manor/nursing home setting.
- assessment of forensic patients referred for evaluation of fitness to stand trial.
- care of profoundly multi-handicapped individuals whose condition requires care beyond the level provided in any other type of facility.
- "back-up" service to individuals with severe mental illness who live in the community and who experience a relapse or whose primary caregivers may require a respite service.

In order for Hillsborough Hospital to effectively play a significant complementary role in the mental health system, it must be recognized as a critically important, multi-service component of the formal mental health service system and staffed accordingly.

3.5 Services to Children and Adolescents

In recent years, health, educational, correctional, and social service professionals have identified what they consider to be a growing incidence of serious emotional and behavioural distress among young people. There does not seem to be any clear understanding of the cause, or of the true extent of the problem,

but there is common concern within the service system over the inability to satisfactorily address the rising demand and the increasing complexity of the cases.

Resources available for disturbed children and adolescents include: guidance programs of the school system; support services such as counselling, foster care, group home placement and the proposed "LAP" program (under development) through the Division of Child and Family Services; assessment and treatment interventions of Community Mental Health professionals; treatment and rehabilitation services of County Addiction Service agencies; Youth and Probation services of the Department of Justice; and the Adolescent Unit of Hillsborough Hospital.

This is probably adequate as a basic service network, however some components considered necessary to a comprehensive youth service system are not in place in Prince Edward Island. There are deficiencies in the range of residential service alternatives for young people whose mental health problems require their removal from home for treatment.

For example:

- Various social trends over the past five to ten years have adversely affected the availability of effective

foster families. The difficulty in recruiting and retaining foster parents is even greater than usual when placement is sought for individuals whose behaviour is exceptionally disruptive and destructive.

- Although there are five "Level 2" Adolescent Group Homes across the Province, there are no "Level 1" or "Level 3" homes. This serves to restrict both admission and discharge activity in the existing homes, and leads to some inappropriate use of the Group Home program.
- The Adolescent Unit at Hillsborough Hospital, an in-patient treatment program with an in-house education component, serves a number of individuals who would be candidates for placement in a "Level 3" Group Home if such were available. The appropriateness of treating adolescents with behaviour problems in a hospital setting should be questioned, particularly if goals of treatment include the development of personal responsibility and social coping skills, and the prevention of long-term association with/reliance on hospital support.
- Over the past year, 20 children have been admitted by psychiatrists to the Queen Elizabeth Hospital under constant surveillance to contain their uncontrollable behaviour. The hospital can provide only limited treatment to these children - it serves primarily as a very costly refuge.

- The Division of Child and Family Services spends an average of $190,000 a year on a combination of hospital placement and out of province placement for children and adolescents for whom no appropriate residential alternatives can be found locally.

There is a general agreement that, with sufficient resources, in-patient psychiatric services for children and adolescents should be located in a facility that is physically separate from a hospital. If appropriately staffed, such a facility could also offer out-patient services to children and their families and consultation to other agencies working with youth.

The 1978 Mental Health Report had proposed that in-patient psychiatric services to young people could be provided by the general hospitals. This has proven to be an impractical, expensive and only marginally therapeutic use of general hospital pediatric beds. The greater majority of children and adolescents so treated have not been suffering from psychiatric illnesses (such as childhood schizophrenia) but are troubled and troublesome young people, usually between the ages of 12 and 16, whose behaviour is such that there are fears for their safety or the safety of those around them. Often they have been abused, or experienced many traumatic upheavals. Many are wards of the Director of Child

Welfare, who prior to entering hospital were living in foster homes or group homes. Service providers to these children promote the need for a "Level 3" group home to more effectively bridge the gap between the highly structured program of the Adolescent Unit and the current community placements which are relatively unsupervised.

Considering its deficiencies, the adolescent program has developed into a valuable treatment unit over the past ten years. Given its current budget, level of staffing, and physical facility, it is operating at maximum efficiency. But among its significant limitations are - its layout - it has no separate entrance, no office space, no therapy space, no recreation or meal preparation/service area; and, -its staff complement - it has only part-time psychiatric and social work input, no psychologist, limited access to occupational therapy service through the main hospital program, and psychiatric attendants working in front line positions that would be better filled by social service workers who had training and experience working with troubled youth.

An Adolescent Program Committee has been established at Hillsborough Hospital to address the most pressing needs for appropriate service to the youth population. The work of this Committee should continue and its results should be made available to the proposed Working Group for consideration in conjunction with proposals on other outstanding issues.

In spite of their efforts to keep step with new issues and caseload pressures, most of the agencies find they are ill-equipped to respond to current levels of demand for service. Contributing factors include: limited assessment capability, limited access to specialized case consultation, inadequate in-service training and development, and insufficient time for inter-agency liaison and co-ordination. The result, too frequently, is a service system skewed by continual crisis.

But along with these operational issues are broader, more serious issues.

There does not seem to be any common understanding of the underlying causes of, or influences on, mental health and mental health problems among young people in Prince Edward Island. Nor does there seem to be a consistent, coherent, contemporary philosophical and policy base guiding the provisions of service and the use of resources. Without these, it is difficult to accurately respond to outstanding system needs - to determine how assessment will be approached, what specialized consultation should be sought, in what areas staff should be engaged in training and development, what priority should be placed on inter-agency relations for what purposes, and whether/how/which existing resources might be redirected to more effective uses.

Each service in the system should reflect in practice a commitment to shared beliefs about mental health, to shared social and service goals, and to each agency's role in achieving them. There is a need for local research, and for an analysis of the findings of research conducted elsewhere. There is a need for on-going joint planning among major service providers to establish agreement on priorities and to develop a schedule and process for addressing them. The identification and pursuit of opportunities for improved resource management is important. Most important for service to the youth population is a strong policy and management commitment to the promotion of mental health and the development of life management skills.

The disturbing trend in escalating mental health problems among adolescents and children points to a rather frightening future! All of society has a stake in seeing the trend reversed and the incidence minimized.

3.6 Community Services

The mental health service plan proposed in the report of the 1978 Advisory Committee and confirmed by participants in the follow-up 1981 Mental Health Services Review, had at its heart the development of a broad range of community based residential, vocational, social, and recreational options both to prevent

hospitalization and facilitate the deinstitutionalization of patients from Hillsborough Hospital.

> "The lack of community based services and consultation has probably resulted in a higher than necessary admission rate to the mental hospital of individuals who might otherwise have been treated at home, or in their local community."[15]

> "The Committee considers that the mental health needs of Islanders can be met appropriately only by the immediate development of a full range of community based services."[16]

At the time these statements were written, there were very few community based mental health service recognized as such. There was the Foster Care program for former patients of Riverside Hospital, a relatively small aftercare service at Hillsborough Hospital, and part time Mental Health Clinics in Charlottetown.

It was noted in the 1978 Report that a number of services originally established within the Division of Mental Health in the late 1960's (School Guidance, Sherwood Home, Speech Therapy, and General Counselling) had been transferred to other jurisdictions (the Departments of Education and Social Services) in the early

1970's, and that although still available, had shifted in focus largely as a result of statutory requirements and evolving theoretical orientations, and were less visible as "mental health services".

The current Review Committee acknowledges the importance of community based mental health services as a critical factor in the prevention of inappropriate hospitalization.

Unfortunately, most service agencies lack the resources to undertake more than elementary data analysis or evaluation to help them determine the impact of their programs. Nonetheless, a review of some available information has yielded results supporting the need for and value of community programs.

- in 1984 the P.E.I. Division of the Canadian Mental Health Association compared the number of days' readmission to hospital for psychiatric treatment, of members in its New Directions program and of residents in Longworth House, for an equivalent time

period before and after their connection to these programs. It was determined that participation in New Directions had contributed to an overall 73% reduction, and residency in Longworth House had contributed to an overall 90% reduction, in the total number of treatment days among the 96 individuals whose records were surveyed.[17]

- In 1987 the Director of Mental Health tracked the hospital admission and discharge records of a small number of young adults with a pattern of repeat admissions, and found that the cost of hospital care for each of these individuals during their repeated hospitalizations was in the vicinity of $70,000 a year. It is her belief that many of these individuals return to hospital primarily because they lack the capability to manage their lives without a relatively highly structured supportive environment.

The Community component of the mental health system should aim to provide a variety of services to a number of different types of

clients demonstrating mental health problems. There should be a balance between treatment of individuals with serious disabilities and early identification of/intervention in developing difficulties.

Since 1978, there has been progress in the development of a community based mental health service system. Services are delivered by psychiatrists in private practice, by government (three multi-disciplinary Community Mental Health teams, an aftercare medication program, and a day treatment program) and by the P.E.I. Division of the Canadian Mental Health Association, which operates New Directions, (a socio-recreational service) in both Charlottetown and Summerside, and Longworth House, (a 12 bed residential service) in downtown Charlottetown. Government is now working to assist the C.M.H.A. in implementing an integrated, supported residential/vocational development program for people recovering from mental illness. It is intended that this service will be modelled on the New York based Fountain House Club, which has been successful in creating an environment and a program standard to enable its members to gain or recover a sense of purpose, belonging, responsibility, and competence. Absence of the self confidence generated by these factors is considered to be both a cause and an effect of social isolation and a cause of readmission to hospital in many cases. The new program will serve, but will not be restricted to, the young adult population previously described.

Community-based clinical services have experienced growth in the demand for service over the past several years. Since 1981, Community Mental Health Teams have witnessed a 90% increase in caseload. The McGill Centre Aftercare Program, which began with 15 patients in 1981, served 175 this year.

There has been a concerted effort on the part of a number of agencies to improve co-ordination among community services. The development of a liaison nursing service operating between the Queen Elizabeth Hospital and services in the community is a positive illustration of effective co-operation and communication among agencies at the case-by-case level. At the same time, however, effective systems-level co-ordination has been more difficult to achieve because of resource and service deficiencies.

The service areas of most critical need for the mentally ill living in the community appear to be housing and social/vocational integration. Prince Edward Island has not been faced with a housing crisis of the same proportion as has been experienced in larger centres, however, there still appears to be a need for decent, affordable housing units in caring surroundings for people with limited income and limited earning potential. Many individuals with mental illness would come within this category.

As well, there is some concern that the current Foster Care program, which has operated successfully for over 25 years, may begin to break down in the relatively near future. Not only is it becoming increasingly difficult to find families willing and able to accommodate adults with mental illness, but as well, many of the clients currently placed are aging, as are their caretakers. To date, no backup or contingency plan exists for this eventuality.

The Committee's review of existing community services identified a need to develop support services in Prince County.

In 1987, a committee of representatives of Social Services, Community Mental Health, the Prince County Hospital, and the Canadian Mental Health Association, reviewed the needs of 46 individuals in the Summerside area diagnosed as having a long-term mental illness, and concluded that in many of the cases, there was an outstanding need for a support/resource person to carry out an in-home supervision/monitoring/referral/liaison function to prevent a breakdown in the present living situation.[18]

The Review Committee supports in principle the concept proposed by this "East Prince Residential Services Committee". The development of such a service should have the additional benefit of demonstrating creativity and flexibility in the use of resources.

There has been a tendency in the past to develop "facility based" programs (e.g. Group Homes and Sheltered Workshops) which required relocating or grouping clients. While this approach may have been necessary when very few community programs existed, it may be that there are now an adequate number of special residential and vocational facilities and that future service needs are for more mobile workers working in normal community settings to promote, support and strengthen community integration. As the federal government's framework for health promotion, Achieving Health For All, affirms, community care must be viewed in terms of the caring capacity of the community as a whole, and not just of formal institutional and community services.

While considering the need for additional special supports for people with mental illness, the Review Committee was concerned that policy barriers and inadequate communication with respect to existing programs could lead to program duplication and further lack of co-ordination. For example, policies governing placement in some federal training and employment programs effectively exclude many employable individuals with mental illness, through such requirements as: that candidates be discharged from hospital, be free of controlling medication, or participate in training or employment on a full-time basis. These criteria have restricted progress in development of supported, integrated employment for the

mentally ill through regular employment programs. However, alternate, more flexible employment programming is currently being devised on a provincial level through the Employability Enhancement Initiatives funded through both levels of government and delivered through the Departments of Health and Social Services and Industry. Management and staff of mental health services, including those delivered by the Department of Health and Social Services are largely unaware of the new provincial employability development strategies, and have therefore not had or taken the opportunity to consider how they might be applied to the benefit of the mentally ill. This can be easily overcome through improved intra-departmental co-ordination and may yield concrete, targetted employment projects for people with mental illness.

Community support service agents must find ways to help their clients achieve greater integration into community life, both by helping clients to become involved with the broader community and by encouraging others to become involved in the lives of clients. Project P.R.O.V.E., (a 30 month Health and Welfare Canada sponsored project operated from within the Department of Health and Social Services' Central Office since 1986) has demonstrated effective, common sense alternatives to needs assessment and service delivery for a small number of mentally retarded adults living in relative isolation in rural P.E.I. The P.R.O.V.E. concepts and practices,

can be easily applied by anyone trying to help a dependant individual live a fuller, richer, more independent but less isolated life. The Department is now involved in planning for the transition of P.R.O.V.E. from a small scale Demonstration Project to a Community Integration program. In this planning, the needs of the mentally ill should not be overlooked.

3.7 Legislation

The process of reviewing the P.E.I. Mental Health Act has been initiated several times during the past five years, but for a variety of reasons has never been completed. During this period most of the other provinces have passed new mental health legislation.

It now appears that the Uniform Mental Health Act prepared by a committee of the Uniform Law Conference will not be adopted across the country. Its preparation has, however, generated considerable debate on a number of issues, and it can be seen as providing a unifying framework for the legislation of individual jurisdictions.

It is important for P.E.I. to have an act which both reflects current philosophy of care, and facilitates optimal clinical practice.

The existing act has a number of substantial deficiencies (for example, no guidelines for obtaining consent for treatment and or dealing with refusal or incapability to accept treatment, no appeal process for out of province transfers) would be vulnerable for court challenge under the Canadian Charter of Rights and Freedoms.

Recently, efforts have been made by the National Office of the Canadian Mental Health Association to promote the development of community mental health legislation. This would be a major departure from existing mental health acts which are largely concerned with involuntary committal to hospital.

Community mental health legislation has been proposed to promote the redirection of fiscal and staff resources to community based services. The key components of such legislation include statements about the desire for treatment in the least restrictive setting, for access to treatment within the local community wherever possible, and for the right to a quality service regardless of geographic location.

A Bill incorporating these sentiments has received second reading in the Ontario Legislature and has now been sent to committee for further study.

The Review Committee is not necessarily proposing that P.E.I. attempt to bring forward community mental health legislation in the near future, but this is one of a number of issues that might well be addressed by a committee working on a revision of the P.E.I. Mental Health Act.

The System Review Committee recommends that the legislative review process be revived in the very near future. Membership of the legislation review committee should be given careful attention. The committee should have significant representation from psychiatrists who will have to work closely with the act. It should also have available to it the expertise of a departmental solicitor who has had practical experience in working within the existing legislation. Among the initial tasks of the committee would be a review of P.E.I.'s current legislation and a comparison with the acts across the remainder of the country. The task of revising the Act will have to be accomplished in the context of both the Charter and the Criminal Code. Having developed recommendations for new legislation, the Committee should seek comment from various interest groups before drafting a new act. If this process is followed, development of legislation which respects individual rights without compromising access to treatment, should be possible.

CONCLUSION

Throughout this assessment of issues in the mental health service system, the importance of effective system management process has been emphasized.

The development of an overall philosophical direction, the promotion of service principles, the operation of an on-going multi-jurisdictional working group, re-organization of the Mental Health Division, establishment of leadership, planning, co-ordination, staffing and development - these are management functions in need of attention - functions that should, and can, be improved to enable a more efficient operation of the system in the future and more effective decisions about future services.

Although it has taken some time to evolve, within the traditional mental health service system there is a general attitude of co-operation and a common interest in constructive problem solving. Without due care to system management process, these positive factors may be eroded by frustration. With policy and resource support, they can be strengthened and extended throughout the broader related human service system.

RECOMMENDATIONS

1. That achievement of a better balance among health promotion, illness prevention, and various levels of treatment be adopted by government as a social policy goal of high priority.

2. That the general principles outlined by the Review Committee be adopted by government as an appropriate basis for further system development.

3. That a permanent Working Group be established by Government under the leadership of the Director of Mental Health, with representation from the senior management levels of the chief components of the mental health, social services and community service system - to participate in on-going system/service problem solving, planning, analysis, evaluation, adjustment, and development.

4. That Mental Health resources and reporting relationships within the Department of Health and Social Services be re-organized so that both Hillsborough Hospital and Community Mental Health are part of the Division of Mental Health.

5. That the Hillsborough Hospital Act be repealed and the Board of Directors be abolished.

6. That a full-time senior position be created within the Division of Mental Health to provide analytical, administrative, management, and planning support to the Director of Mental Health and to serve as a staff resource to the Working Group.

7. That the Province make every possible effort to recruit a second psychiatrist to serve as Physician-in-Chief at Hillsborough Hospital to enable the Director of Mental Health to undertake the many system management responsibilities in need of attention.

8. That the allocation and use of acute care psychiatric beds at the two general hospitals and Hillsborough Hospital be examined with a view to establishing a bed management plan for psychiatry.

9. That Hillsborough Hospital be recognized as a critically important, multi-service component of the formal mental health service system and that the Department of Health and Social Services assign a high priority to upgrading levels of (nursing) staffing at Hillsborough Hospital.

10. That the feasibility of removing the Adolescent Unit from Hillsborough Hospital and establishing a more appropriate youth service, be explored.

11. That the Queen Elizabeth Hospital (Pediatric Department) no longer be used to house children and adolescents with behaviour problems and that more suitable alternatives be sought immediately.

12. That the Working Group establish a sub-committee (a) to collect, analyze, and present data on the reasons for use of mental health services by children and adolescents in P.E.I., the types of service provided, and the results (b) to develop a process for planning among major service providers which will establish their roles and goals, and facilitate agreement on priorities and preventive service measures.

13. That Government adopt a strong policy and management commitment to the promotion of mental health and the development of life management skills in mental health services.

14. That planning staff of the Department of Health and Social Services consult with the Director of Mental Health and work with the P.E.I. Housing Corporation to ensure that the housing needs of the mentally ill in the community are addressed in Housing Corporation plans and priorities (e.g. development of low income housing projects, special purpose housing, etc.).

15. That the Director of Mental Health initiate an examination of the Hillsborough Hospital Foster Care Program, emphasizing individual case planning, and leading to an increased understanding of the nature and urgency of future service needs of individuals now in foster placements.

16. That the Department of Health and Social Services Vocational Services staff (Job Creation and Placement, Employability Enhancement, Project P.R.O.V.E.) develop means of improving communication and liaison with management and staff of mental health services with a view to improving the employment potential of individuals in the community with mental illness.

17. That the Minister of Health and Social Services establish a small committee to revise the P.E.I. Mental Health Act, and that:

- the committee include representation from practicing psychiatrists who will work under new legislation.
- the committee include a solicitor who has had practical experience working with the existing legislation.

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